MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

CERTIFICATE OF DEATH

06847

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 7 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 W. Saratoga St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SARAH ELIZABETH ANDREWS

3.(b) Social Security Number: 217-12-9818

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Cecil H. Andrews

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): January 25, 1923

8. AGE: Years	Months	Days	If less than one day
22	5	6	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER
12. Name: Walter Stansbury
13. Birthplace: Virginia

MOTHER
14. Maiden name: Rebecca Howard
15. Birthplace: New Castle, Delaware

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) 7 (day) 5 (year) 45
Cemetery or crematory Mt. Calvary
Location
18. Funeral director Adolphus Halstead
Address 918 Druid Hill Ave

19. (Date rec'd by registrar) 7/1 19 45 Albert R. Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 19 45 at 2.25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 19 45 to July 1, 19 45 and that I last saw her alive on July 1 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Mar. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md. Date signed 7/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JUL 3 1945
DUMBARTON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH ★

06848

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural (Westminster)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural (Westminster)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emily Jane Arnold

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Anthony Arnold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 19 - 1860

8. AGE: Years	Months	Days	If less than one day
84	7	22	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Martin Bitzel

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth —

15. Birthplace Carroll Co. Md.

16. Informant Mr. Howard Garner

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13. 1945. (month) (day) (year)

Cemetery or crematory Pennpark Cem.

Location Smallwood, Carroll Co. Md.

18. Funeral director H Bankard Sons

Address Westminster Md.

19. 7/11 19 45 T Elwood (Registrar)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1944 to July 11, 1945 and that I last saw h.. alive on June 5, 1945

Immediate cause of death	DURATION
Myocardial degeneration	2 yrs
Due to	
Due to	
Other conditions Edema	6 mos

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C Reese Wilkens M.D.
M. D. or other

Address Westminster Md. Date signed 7-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

06849

CERTIFICATE OF DEATH

★ Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 1 mo 26 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Maria Askey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 15, 1888

8. AGE:

Years	Months	Days	If less than one day
57	0	6	hrs. min.

9. Birthplace: Pekin Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John L. Askey

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Harriet Yost

MOTHER — 15. Birthplace: Pennsylvania

16. Informant: Hospital Records

Address: Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1945 (month) (day) (year)

Cemetery or crematory: Lonaconing

Location: Allegany Co., Md.

18. Funeral director: C. Harry Klee

Address: Sykesville, Md.

19. July 21 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1945 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7, 1943 to July 21 1945 and that I last saw her alive on July 20, 1945

Immediate cause of death	DURATION
Carcinoma of gall bladder	2 yr
Due to: Cholelithiasis	8 yrs
Other conditions: Pernicious Anemia	8 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Maud M. Rea M.D.
M. D. or other

Address: Sykesville Md Date signed 7-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C6850

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 1 day
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 524 W. Biddle St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: QUEEN ESTHER BALDWIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5, 1921

8. AGE: Years	Months	Days	If less than one day
24	0	0	hrs. min.

9. Birthplace: Lumberton, N. C.
(Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Octavia McCall
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-45 (month) (day) (year)
Cemetery or crematory: Lumberton
Location: North Carolina
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave

19. 7/5/ (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5, 19 45, at 1.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 19 45, to July 5, 19 45
and that I last saw her alive on July 5, 19 45

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Dec. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other
Address: Henryton, Md. Date signed 7/5/45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46d)

06851

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs 1 mo 12 dd
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 9 yrs 1 mo 12 dd

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1427 North Central Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Becker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Joseph Becker
Unknown 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) August 20, 1885

8. AGE: Years	Months	Days	If less than one day
59	11	8	hrs. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name William Welsh
13. Birthplace unknown

MOTHER
14. Maiden name (Unknown) Regina Hurdel
15. Birthplace unknown

16. Informant Hospital Records
Address Sykesville Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7-29-45 (month) (day) (year)
Cemetery or crematory Catholic
Location Route 1
18. Funeral director Leonard J. Finch
Address 5305 Wayfield Road

19. 7/30/45 (Date rec'd by registrar) D. W. Hedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28th 1945 at 10.10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1936 to July 28 1945 and that I last saw h.C.? alive on July 28 1945

Immediate cause of death	DURATION
Carcinoma of rectum	3 yrs
Due to	
Due to	
Other conditions Paranoid Condition	9 yrs 6 mo

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D. M. D. or other
Address Sykesville Md Date signed 7-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

C6852 ★ Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

Uniontown Road, R.D. #5

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Uniontown Road 3 Miles North Westminster

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Glenn William Bell

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Edith Shreffler Bell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 23, 1897

8. AGE: Years 48 | Months 3 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Greystone Fred Co. Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name George A. Bell

13. Birthplace Fred Co. Md.

MOTHER 14. Maiden name Ida Harbaugh

15. Birthplace Fred. Co. Md.

16. Informant Mrs. Glenn W. Bell

Address Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/45 (month) (day) (year)

Cemetery or crematory Reiders

Location near Westminster Md.

18. Funeral director J. E. Myers Jr.

Address Westminster, Md.

19. 7/9 (Date rec'd by registrar) 19 45 H. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 45 at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 19 45 to July 8 19 45 and that I last saw h... alive on July 8 19 45

Immediate cause of death	DURATION
Tuberculous Pneumonia	10 days.
Due to Tuberculosis of Testicle +	
Due to Epididymitis	3 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Luther Bare (M.D.) (M. D. or other)

Address Westminster Maryland Date signed 7/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bc)

CERTIFICATE OF DEATH

66853

★ Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs., 9 mos., 26 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 12 yrs., 9 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 2838 W. Lanvale St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Elizabeth Brookhart

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16, 1915

8. AGE: Years	Months	Days	If less than one day
30	3	3	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: ?

11. Industry or business

FATHER — 12. Name: John Brookhart

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: ?Emrine

MOTHER — 15. Birthplace: Maryland

16. Informant: Records of Springfield State

Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21, 1945 (month) (day) (year)

Cemetery or crematory: Landon Park Cem.

Location: Balto. Md.

18. Funeral director: Williams Cook Inc.

Address: 1217 St. Paul St.

19. July 20 1945 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1945 at 8:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16th 1945 to July 19th 1945 and that I last saw h.e.a. alive on July 19th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 months
Due to	
Due to	
Other conditions Epilepsy	25 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Helmut Prager M.D. M. D. or other

Address: Springfield State Hospital, Md. Date signed: 7-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

06854

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 50 Years

Hospital, institution, or street address where death occurred:

25 Union St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town West Minster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Union St #25

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leonelius Brown

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Widowed

8.(b) Name of husband or wife Annie Sider Brown

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1855

8. AGE: Years	Months	Days	If less than one day
90	4	22	..... hrs. ..... min.

9. Birthplace Morgan Run, Carroll Co., Md.

(Town, county, and state)

10. Usual occupation day laborer (retired)

11. Industry or business

FATHER

12. Name Joshua W. Brown

13. Birthplace Md.

MOTHER

14. Maiden name Eliza Gaversell

15. Birthplace Md.

16. Informant Wellington Brown

Address Union St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/6/45 (month) (day) (year)

Cemetery or crematory Ellerslie Cemetery

Location near Westminster Md.

18. Funeral director J. S. Myers Jr.

Address Westminster Md.

19. 7/5 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 45 at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	—
Due to Generalized Arterio Sclerosis.	
Due to	
Other conditions Epilepsy	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Thomas Deputy Medical Examiner M. D. or other

Address Westminster Md. Date signed 7/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

06855

CERTIFICATE OF DEATH

★ Reg. Diat. No. 71

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 82
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Archibold Buchman

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Celeclia Buchman
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Jan. 4 1863

8. AGE:

Years	Months	Days	If less than one day
82	6	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Painter Paperhanger
11. Industry or business: Painting
FATHER 12. Name: Jacob Buchman
13. Birthplace: Maryland
MOTHER 14. Maiden name: Catherine Zepp
15. Birthplace: Maryland
16. Informant: Celeclia Buchman
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-16-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Lutheran
18. Funeral director: Jacob Winks Sons
Address: Manchester Md.
19. July 15 1945 Mrs. W. P. S. Dennes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1945 at 6.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1944 to July 13 1945
and that I last saw h[illegible] alive on July 13 1945

Immediate cause of death	DURATION
Cardiac failure	1 day
Due to: Myocardial degeneration	
Due to:	
Other conditions: Arteriosclerotic gangrene right foot	4 months

(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. V. Sohler M.D.
M. D. or other
Address: Manchester Md Date signed: 7-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

06856

★ Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bertha B. Carter

3.(b) Social Security Number H

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife James L. Carter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 14, 1887

8. AGE: Years 57 | Months 8 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name Edmund C. Jenkins
13. Birthplace Md.

MOTHER
14. Maiden name Alice V. Easton
15. Birthplace Md.

16. Informant Mrs Raymond Arrington
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15, 1945 (month) (day) (year)

Cemetery or crematory Wesley Freedmen Cemetery

Location Eldersburg, Carroll Co., Md

18. Funeral director C. Harry Myers

Address Sykesville, Md

19. July 14 1945 (Date rec'd by registrar) C. Harry Myers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945 about at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

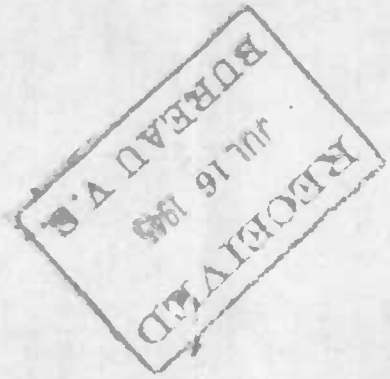
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE James L. Thomas M. D. or other

Address Westminster Md Date signed 7/12/45


RECEIVED
JUL 16 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06857

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 11 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 1, Box 94-A
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: BEATRICE ISABELL COOPER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1921

8. AGE: Years	Months	Days	If less than one day
23	7	23	hrs. min.

9. Birthplace: Easton, Md.
(Town, county, and state)

10. Usual occupation: Factory Worker

11. Industry or business:

FATHER
12. Name: John Cooper
13. Birthplace: Easton, Md.

MOTHER
14. Maiden name: Lucinda Hinton
15. Birthplace: Easton, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial. (Burial, cremation, or removal. Which?) Date thereof July 26/45. (month) (day) (year)

Cemetery or crematory: Copperville, Md.

Location: Near Easton, Md.

18. Funeral director: John O. Mitchell Sons

Address: 1900 Eutaw Pl. Balto. Md

19. July 24, 1945 (Date rec'd by registrar)

Albert R. Swanston
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24, 1945, at 10:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13, 1945 to July 24, 1945 and that I last saw her alive on July 24, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 7-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06858

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 6 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: STAUZY ALEXANDER COPLIN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 17, 1910

8. AGE: Years	Months	Days	If less than one day
34	10	14	hrs. min.

9. Birthplace: Gaithersburg, Md.
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business

FATHER
12. Name: Albert Coplin
13. Birthplace: Gaithersburg, Md.

MOTHER
14. Maiden name: Mary Washington
15. Birthplace: Gaithersburg, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 45 (month) (day) (year)
Cemetery or crematory: Brookmont
Location: Layton Hill mausoleum
18. Funeral director: Robert L. Snodsbert
Address: Rockville Md

19. July 31, 19 45 (Date rec'd by registrar)
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 19 45, at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25, 19 45 to July 31, 19 45 and that I last saw him alive on July 31, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1945
Due to:
Due to:
Other conditions: Tuberculous Peritonitis
(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Md. Date signed 7-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

06859

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 2 yrs 9 mo 9 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 9 mo 9 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Unknown (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Frances E. Cramwell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 17- 1861

8. AGE: Years 84 | Months 2 | Days 20 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Dependent.

11. Industry or business:

FATHER 12. Name: Charles Cramwell

13. Birthplace: Virginia

MOTHER 14. Maiden name: Susan Pollard

15. Birthplace: Virginia

16. Informant: Mrs. Helen Beatty

Address: 142 N Potomac St Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown

18. Funeral director: C M Suter & Sons

Address: 505-07 Pot St Hagerstown

19. July 8 1945 (Date rec'd by registrar) C. Henry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7th 1945 at 8:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1942 to July 8th 1945 and that I last saw h alive on July 8th 1945

	DURATION
Immediate cause of death:	
Due to: Chronic Hypertension	10 yrs
Due to: Sub Acute Sclerosis	15 yrs
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. J. Masten M.D. M. D. or other

Address: Sykesville Md. Date signed: 7/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

06860

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll.
City or town: near Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs., 1 mo., 0 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 9 years, 1 month.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5516 Carville Ave. (Halethorpe).
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frederick Crowther.

3.(b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Widowed.

6.(b) Name of ~~husband or~~ wife: Frances Shaw.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 6, 1867.

8. AGE: Years	Months	Days	If less than one day
77.	8.	5.	..... hrs. ..... min.

9. Birthplace: New York, N. Y. (town, county, and state)
10. Usual occupation: Laundry worker.
11. Industry or business:
FATHER — 12. Name: John Henry Crowther.
FATHER — 13. Birthplace: England.
MOTHER — 14. Maiden name: Lydia — ?
MOTHER — 15. Birthplace: England.
16. Interment: Springfield Hospital Record.
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-13-45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto. Md.
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Rd. Balto. Md.
19. July 11 1945 (Date rec'd by registrar) C. Harry Baer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1945 at 10 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 1937, to July 11, 1945, and that I last saw him alive on July 11, 1945.

Immediate cause of death	DURATION
Coronary Thrombosis	30 min.
Due to:	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis — prior to 6-11-36.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 7-11-45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-E)

CERTIFICATE OF DEATH

06861 76

Reg. Dist. No. .....

1. PLACE OF DEATH:

County CARROLL

City or town RURAL WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLL

City or town RURAL WESTMINSTER, MD.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ARTHUR FRANCIS DANZ

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife IRENE WHITELING

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) APRIL 6, 1888

8. AGE:

Years	Months	Days	If less than one day
57	2	26	....hrs. ....min.

9. Birthplace LONG ISLAND, N.Y. (Town, county, and state)

10. Usual occupation SALESMAN

11. Industry or business

FATHER

12. Name JOHN G. DANZ

13. Birthplace NOT KNOWN

MOTHER

14. Maiden name FRANCES HAFF

15. Birthplace NOT KNOWN

16. Informant MRS A. E. DANZ

Address WESTMINSTER, MD. R.6.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/5/45 (month) (day) (year)

Cemetery or crematory KRIDER'S CEMETERY

Location NEAR WESTMINSTER, MD.

18. Funeral director J. FRANCIS REESE

Address WESTMINSTER, MD.

19. 7/3 (Date rec'd by registrar) 19 45 by [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 45, at 7 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 19 45, to July 5th 19 45

and that I last saw h.. alive on July 5th 19 45

Immediate cause of death	DURATION
Chronic Nephritis -	5 years
Due to Chronic Myocarditis	3 years
Due to a	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] (M.D.) M. D. or other

Address Westminster, Md. Date signed 7/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06862

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 646 Greenwillow Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LENORA MINNIE DOBBINS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 8, 1911

8. AGE: Years	Months	Days	If less than one day
33	11	2	hrs. min.

9. Birthplace: Wilson County, Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: John Dobbins
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Daisy Epps
MOTHER 15. Birthplace: Virginia
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14, 1945 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cemetery
Location:
18. Funeral director: Mrs. Frances I. Hemsley
Address: 578 W. Biddle St. Balto, Md.
19. July 10, 1945 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10, 1945, at 11:35 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1945, to July 10, 1945 and that I last saw her alive on July 10, 1945
Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1944
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)
Address: Henryton, Md. Date signed: 7-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06863

★ Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Berrett (R.D. Sykesville, Md)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: R.F.D. Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eyard Dorsey

3.(b) Social Security Number 4 #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary Eliz. Dorsey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 16, 1872

8. AGE:

Years	Months	Days	If less than one day
73	3	0	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: William A. Dorsey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary A. Leatherwood
15. Birthplace: Maryland

16. Informant: Mrs. Mary Eliz. Dorsey
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1945 (month) (day) (year)

Cemetery or crematory: Wesley Freedom Cem.

Location: Eldersburg Carroll Co. Md.

18. Funeral director: C. Harry Wm

Address: Sykesville, Md.

19. July 18 1945 (Date rec'd by registrar) C. Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1945, at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945, to July 16 1945 and that I last saw him alive on July 16, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 da
Due to: Arterio-sclerosis	? yrs
and Hypertension	? yrs
Due to:	
Other conditions: Chr. Myocarditis	? yrs
Old cerebral hemorrhage	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other

Address: Mt. Airy, Md. Date signed 7/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (38)

CERTIFICATE OF DEATH

06864

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: near Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs., 10 mos., 8 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital.
How long in hospital or institution? 40 yrs., 10 mos., 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1424 McHenry.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph A. Eliason.

3.(b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Widowed (?)

6.(b) Name of ~~husband or~~ wife: Unknown.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1866.

8. AGE:

Years	Months	Days	If less than one day
79.	?	?	hrs. min.

9. Birthplace: Maryland.
(Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business

FATHER
12. Name: William A. Eliason.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Eliza Rodgers.
15. Birthplace: Maryland.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof July 13, 1945 (month) (day) (year)
Cemetery or crematory: Springfield State Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Eiler
Address: Sykesville, Md.
19. July 13, 1945 (Date rec'd by registrar) C. Harry Eiler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9, 1945, at 12.15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936, to July 8, 1945
and that I last saw him alive on July 8, 1945.

Immediate cause of death	OURATION
Chronic Myocarditis	2 yrs.
Due to General Arteriosclerosis with Hypertension.	10 yrs.
Due to	
Other conditions Alcoholic Psychosis - Paranoid prior to 8-31-04.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry J. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed 7-9-45.

66865

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:
County: Carroll
City or town: Salem
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Salem
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. 6 Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HARVEY L. FRIZZELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertie E. Frizzell
6.(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): April 2, 1880

8. AGE: Years	Months	Days	If less than one day
65	3	0	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Insurance Salesman
11. Industry or business:

FATHER
12. Name: William Y. Frizzell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Henrietta Lindsay
15. Birthplace: Maryland

16. Informant: Mrs. Bertie E. Frizzell
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-5-45 (month) (day) (year)
Cemetery or crematory: Salem
Location: Salem, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. July 4 19 45 (Date rec'd by registrar) C. M. Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5th 19 45, at 6 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10th 19 44, to July 5th 19 45
and that I last saw h[illegible] alive on July 4th 19 45

Immediate cause of death	DURATION
Lobar Pneumonia -	2 days
Due to	
Myasthenia Gravis	Duration
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] (M.D.) M. D. or other
Address: Westminster Maryland Date signed 7/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

06866

CERTIFICATE OF DEATH

★ Reg. Diat. No. 83

1. PLACE OF DEATH:
County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or towe: Woodbine
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME THOMAS F. GOSNELL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lurena M. Gosnell
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 12, 1863

8. AGE: Years	Months	Days	If less than one day
82	4	12	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Farmer --retired
11. Industry or business
FATHER 12. Name: Jesse Gosnell
13. Birthplace: Maryland
MOTHER 14. Maiden name: Ann Thomas
15. Birthplace: Maryland
16. Informant: Mrs. E. W. Pickett
Address: Woodbine, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-27-45 (month) (day) (year)
Cemetery or crematory: Morgan Chapel
Location: Day, Carroll Co. Md.
18. Funeral director: C. M. Waltz
Address: Winfield, Md.
19. July 28 1945 (Date rec'd by registrar) Edna M. Hewitt Deputy Clerk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1945 at 5:30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 23 1945 to July 24 1945 and that I last saw him alive on July 24 1945

Immediate cause of death	DURATION
Uremia - acute	
superimposed on chr. uremia	2 yrs
Due to Chr. Interstial Nephritis	? yrs
Due to Arteria - Sclerosis	? yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findiogs of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please nnderline the canse to which death shonld be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (Connty) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Stanley Gralrill M. D. or other
Address: Mt Airy, Md Date signed 7/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

06867

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 6 mos., 25 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yrs., 6 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Not known
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Morris Gowdy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single?

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1881?

8. AGE: Years	Months	Days	If less than one day
64 ?	?	?	hrs. min.

9. Birthplace: Not known (Town, county, and state)

10. Usual occupation: Not known

11. Industry or business:

FATHER
12. Name: Not known
13. Birthplace: Not known

MOTHER
14. Maiden name: Not known
15. Birthplace: Not known

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto. Md.

18. Funeral director: Williams Coach Inc.
Address: 1217 N. Paul St.

19. July 21 1945 (Date rec'd by registrar) C. Gerry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1945, at 9 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31st 1945, to July 19th 1945
and that I last saw him alive on July 19th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 months
Due to:	
Due to:	
Other conditions: Post traumatic convulsive disorder	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Helmuth Trager M.D.
M. D. or other
Address: Springfield State Hospital MD Date signed: 7-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06868

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 22 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural - Sykesville

(If outside city or town limits write RURAL and give nearest town)

Street No.: Springfield State Hospital (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Oscar Peter Grau

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28 1887

8. AGE: Years: 56 | Months: 1 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Baltimore Co. Md. (Town, county, and state)

10. Usual occupation: Inmate -

11. Industry or business:

FATHER — 12. Name: O. Peter Grau

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anna P. Mamberger

15. Birthplace: Maryland

16. Informant: Hospital Records

Address:

17. Burial, cremation, or removal. Which?: Burial Date thereof: July 20-1945 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Baltimore Md

18. Funeral director: A. Bailey Slade

Address: 4907 York Road

19. 7/20 1945 Rob. Schmidt Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1945, at 10:15 PM Prior to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Drowning -

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of: July 19-1945

Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?): S.S.H.

Means of injury: Slipped off dam Injured at work? No.

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: 7/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

06869

Reg. Dist. No. 71

1. PLACE OF DEATH:

County Carroll

City or town Taneytown Rural Route #1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural Route #7
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rosemary Hahn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1945

8. AGE: Years — Months — Days — If less than one day 3 hrs. 45 min.

9. Birthplace Taneytown, Carroll, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Donald G. Hahn

13. Birthplace Taneytown, Md.

MOTHER 14. Maiden name Romaine Sullivan

15. Birthplace Taneytown, Md.

16. Informant Donald G. Hahn

Address Westminster, R#7, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31, 1945 (month) (day) (year)

Cemetery or crematory Keysville Cemetery

Location Keysville, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19 July 31 19 45 Mary B. Witt Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31 19 45 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-31 19 45 to 7-31 19 45 and that I last saw h... alive on 7-31-45 19 45

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury J. H. Legg Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Date signed 7-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G 97 JUL 27 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06870

Reg. Dist. No. 75

1. PLACE OF DEATH:

County Carroll

City or town Taneytown Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George W. Hess

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Clara E. Hess

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1846 1856

8. AGE:	Years	Months	Days	If less than one day
	89	1	14	hrs. min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation teacher and farmer

11. Industry or business

FATHER 12. Name Samuel Hess

13. Birthplace Md.

MOTHER 14. Maiden name Ann Cornell

15. Birthplace Md.

16. Informant Mrs. Clara E. Hess

Address Taneytown, Md. R.D.

17. Burial Date thereof July 3, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Frederick, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. July 3, 19 45 Ethel M. Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1945 at 1:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28th 1945, to July 1st 1945 and that I last saw h[illegible] alive on June 30th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions Arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner M D
M. D. or other

Address Taneytown Md Date signed July 1st 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06871

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 4 mos. 4 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 607 Dolphin St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JAMES HILL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 24, 1938

8. AGE:	Years	Months	Days	If less than one day
	7	0	26	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: --

11. Industry or business: --

FATHER

12. Name: Clarence Hill

13. Birthplace: Lawrence, South Carolina

MOTHER

14. Maiden name: Effie Fowler

15. Birthplace: Lawrence, South Carolina

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-22-45 (month) (day) (year)

Cemetery or crematory: Cet. Mayne

Location: Baltimore, Md

18. Funeral director: [illegible]

Address: 578 W. Biddle St.

19. July 20, 1945 (Date rec'd by registrar) Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20, 1945, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1942 to July 20, 1945 and that I last saw him alive on July 20, 1945

Immediate cause of death: Tuberculous Peritonitis — DURATION: May 1940

Due to: Primary Tuberculosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 7-20-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06872

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 22 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2419 Etting Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROSA HOLDEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct., 5, 1913

8. AGE: Years	Months	Days	If less than one day
31	9	1	hrs. min.

9. Birthplace: St. Mary's Co., Md. (Town, county, and state)
10. Usual occupation: Maid
11. Industry or business

FATHER
12. Name: Benjamin Holden
13. Birthplace: Maryland

MOTHER
14. Maiden name: Cora Hall
15. Birthplace: St. Mary's Co., Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9-45- (month) (day) (year)
Cemetery or crematory: Mt. Auburn.
Location: Baltimore, City.

18. Funeral director: Geo. G. Kelson
Address: 803 Presstman, St.

19. 7/7 (Date rec'd by registrar) 1945 Albert B. Lemmon Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1945, at 12.05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 1944 to July 6, 1945 and that I last saw her alive on July 6, 1945

Immediate cause of death	DURATION
Tuberculosis of the hip	July 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Maryland Date signed 7/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)(a)

CERTIFICATE OF DEATH

06873

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: FINKSBURG
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: FINKSBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: EDITH FINDLEY HORNER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): NOV. 7, 1882

8. AGE:

Years	Months	Days	If less than one day
62	8	24	..... hrs. ..... min.

9. Birthplace: FINKSBURG, CARROLL, MD.
(Town, county, and state)

10. Usual occupation: GENERAL STORE

11. Industry or business

FATHER
12. Name: GEORGE W. HORNER
13. Birthplace: MD.

MOTHER
14. Maiden name: ADELAIDE WICKERT
15. Birthplace: MD.

16. Informant: MAUDE HORNER
Address: FINKSBURG, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 8/2/45 (month) (day) (year)

Cemetery or crematory: FINKSBURG CEM.

Location: FINKSBURG, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 8/1 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 31 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/36 19 ..., to 7/31/45 19 ...
and that I last saw h.. alive on 7/31/45 19 ...

Immediate cause of death: Myocarditis — Chronic — DURATION: years

Due to: Hypertension — 10 yrs

Due to: Nephritis

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. Talbot M. D. or other

Address: Westminster, Md. Date signed 8/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

06874

CERTIFICATE OF DEATH

★ Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Laura Jane Hunt

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(c) If alive, give age: 81 years

B.(b) Name of husband ~~or wife~~: John L. Hunt

7. Birth date of deceased (mo., day, yr.): June 14. 1871

8. AGE:

Years	Months	Days	If less than one day
74	1	5	...hrs. ...min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business:

FATHER
12. Name: John Warfield
13. Birthplace: Germany

MOTHER
14. Maiden name: Rigina Gunther
15. Birthplace: Unknown

16. Informant: John L. Hunt
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-22-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Lutheran

18. Funeral director: Jacob Winks & Sons
Address: Manchester Md

19. July 20 1945 Mrs. W. P. L. Benner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1945, at 2.30 a M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Jan 3, 1945 to July 19 1945 and that I last saw h[illegible] alive on July 18 1945

Immediate cause of death	DURATION
Carcinoma of Rectum	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jas. E. Bush M. D.
M. D. or other
Address: Hampstead Md. Date signed 7/20, 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06875

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yr., 6 mo., 10 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 7 yr., 6 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Shannon Imes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 24, 1878

8. AGE: Years	Months	Days	If less than one day
66	9	0	..... hrs. ..... min.

9. Birthplace: Allegany County, Maryland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: David H. Imes
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Amanda Elbin
15. Birthplace: Pennsylvania

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Cumberland, Md.
18. Funeral director: Wm. H. Light
Address: Cumberland, Md.

19. July 24 1945 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1945 at 1:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to July 24 1945 and that I last saw him alive on July 23 1945

Immediate cause of death	DURATION
Chronic myocarditis & myocardial degeneration	1 year
Due to: Arteriosclerosis, prior to	1944
Due to:	
Other conditions: Manic-depressive psychosis, manic type	8 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robt Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 7-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

06876

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 11 mos. 12 dys.

Hospital, Institution, or street address (if not in hospital): Spring Field State Hospital

How long in hospital or institution? 1 yr 11 mos 12 dys

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Rose O Irvin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Edward Irvin

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 10th 1874

8. AGE: Years: 71 | Months: 3 | Days: 22 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Mary Land. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At home

FATHER — 12. Name: William Moore

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace:

16. Informant: Mrs Pauline Eckstine

Address: 17 Greenmount Ave Hagerstown Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 7/5/45 (month) (day) (year)

Cemetery or crematory: Mt Lena Cem.

Location: Washington Co., Md.

18. Funeral director: Wm E. Bast & Son

Address: Boonsboro, Md.

19. (Date rec'd by registrar) July 3 1945 C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2d 19 45, at 1-05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 19 43, to July 2 19 45

and that I last saw her alive on July 2 19 45

Immediate cause of death: Acute Coronary occlusion — DURATION: 1 da

Due to: Cerebral Arterio Sclerosis — DURATION: 1 yrs.

Due to: Hypertension — DURATION: ? ?

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M. D. (M. D. or other)

Address: Sykesville Md. Date signed: 7/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06877

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs. 1 mo. 16 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 13 yrs., 1 mo., 16 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 37, Wilson Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: ELSIE G. JENKINS.

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Andrew Jenkins.
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): April 30, 1882

8. AGE: Years	Months	Days	If less than one day
63	2	16	....hrs. ....min.

9. Birthplace: Frederick County, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Thomas M. Wachter
13. Birthplace: Fred. Co. Md.

MOTHER
14. Maiden name: Cynthia Mesnell
15. Birthplace: Fred. Co. Md.

16. Informant: Hospital records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-18-45 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Frederick-Md.
18. Funeral director: C. E. Cline & Son
Address: Frederick-Md.

19. July 16 1945 (Date rec'd by registrar) C. Harry Zeiler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 19 45 at 1.50 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1932, to July 16 1945 and that I last saw h.... alive on July 16 1945

Immediate cause of death	DURATION
Chronic Myocarditis	-
Due to	
Due to	
Other conditions Pulmonary Tuberculosis	15 yrs.
Dermatitis Placare	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other
Address: S. S. Hosp. Sykesville, Md. Date signed 7-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06878

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 12 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: 647 Pierce St.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM HENRY JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1922

8. AGE:	Years	Months	Days	If less than one day
	23	6	29	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: William Johnson
13. Birthplace: Unknown

MOTHER
14. Maiden name: ? Boswell
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/2/45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.

18. Funeral director: A. Tolbert
Address: 918 Druid Hill Ave

19. July 30, 1945 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1945 at 6:30A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1945, to July 30, 1945 and that I last saw him alive on July 30, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Aug. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 7-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Diat. No. 06879 · 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs, 5 months, 15 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 14 N. Caroline Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ANNIE WHITE JONES

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: James Jones
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 17, 1905

8. AGE: Years	Months	Days	If less than one day
40	3	19	hrs. min.

9. Birthplace: Norfolk, Va. (Town, county, and state)
10. Usual occupation: Maid
11. Industry or business:

FATHER
12. Name: Charles Young
13. Birthplace: New York

MOTHER
14. Maiden name: Gussie Freeman
15. Birthplace: N. Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: B. A. Co., Md.
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley ave

19. July 6, 1945 (Date rec'd by registrar) Albert R. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1945 at 7:02 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21, 1943 to July 6, 1945 and that I last saw her alive on July 6, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Dec. 1942
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 7-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06880

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 month, 3 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 514 N. Calhoun St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES EDWARD JONES

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Violetta Jones
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 1, 1912

8. AGE: Years	Months	Days	If less than one day
32	11	18	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Presser
11. Industry or business

FATHER
12. Name: Edward Jones
13. Birthplace: Virginia

MOTHER
14. Maiden name: Bessie Young
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/22/45 (month) (day) (year)
Cemetery or crematory: ~~Mt Calvary Cemetery~~ Catoctin Memorial Park
Location: ~~Mt. Calvary Cemetery~~ Frederick County, Md.

18. Funeral director: Charles A. Weber
Address: 512 N. Carrollton Ave.

19. July 19, 1945 (Date rec'd by registrar) Albert L. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1945, at 3:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 1945, to July 19, 1945, and that I last saw him alive on July 19, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1939
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 7-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06881

CERTIFICATE OF DEATH ★

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1302 Myrtle Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE JUBILEE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1903

8. AGE: Years: 42 | Months: 0 | Days: 6 | If less than one day: ..... hrs. ..... min.

8. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business
FATHER 12. Name: Sam Jubilee
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: ? Smith
MOTHER 15. Birthplace: Virginia
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/14/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: G. A. to Md
18. Funeral director: Isaac T. Brown
Address: 108 W Montgomery St
19. July 10, 1945 (Date rec'd by registrar) Albert D. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: July 10, 1945 at 11:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1945, to July 10, 1945 and that I last saw him alive on July 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 7-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06882

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland, County: —
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 727 S. Milton Ave. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FRANK KLESZCZEWSKI

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1899

8. AGE: Years: 45 | Months: 11 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Philadelphia, Pennsylvania (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: Can Company

FATHER — 12. Name: Frank (unknown) Kleszczewski
13. Birthplace: Poland

MOTHER — 14. Maiden name: Marcella (unknown) Romanowska
15. Birthplace: Poland

16. Informant: Hospital records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 5, 1945 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Mt. Carmel Road, Baltimore

18. Funeral director: M. J. Sadowski & Son
Address: 1808 Eastern Avenue

19. 7/3 (Date rec'd by registrar) 19 45 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 19 45 at 2 53 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 19 45 to July 1 19 45 and that I last saw him alive on July 1 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs.
Due to:	
Due to:	
Other conditions: Empyema with Uremia, Alcoholism	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other
Address: V.A. Hosp. Sykesville, Md. Date signed: 7-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06883

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

VS A15 (T) (I) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yr., 6 mo., 29 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 26 yr., 6 mo., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: rural near Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Charles C. Manyett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

8.(b) Name of husband or wife
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 2, 1890

8. AGE: Years	Months	Days	If less than one day
54	9	23	..... hrs. ..... min.

9. Birthplace: Hagerstown, Washington Co., Md
(Town, county, and state)

10. Usual occupation: common labor

11. Industry or business

FATHER
12. Name: J.B. Manyett
13. Birthplace: Virginia

MOTHER
14. Maiden name: Alice Colwain
15. Birthplace: Virginia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29, 1945 (month) (day) (year)
Cemetery or crematory: Boonsboro Cem.
Location: Boonsboro, Md.

18. Funeral director: Wm F. Bast & Son
Address: Boonsboro, Md.

19. July 27 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1945, at 3:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to July 25 1945 and that I last saw him alive on July 25 1945

Immediate cause of death	DURATION
Acute bronchopneumonia	4 days
Due to: Arteriosclerosis	5 years
Due to:	
Other conditions: Without psychosis, mental deficiency	life

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 7-25-45

06884

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. Westminster - Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Joseph H. Ogle

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name ~~of husband~~ or wife: Katie L. Ogle
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 13, 1879

8. AGE: Years: 66 | Months: 0 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Albert Ogle
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Kelley
15. Birthplace: Maryland

16. Informant: Mrs. J. H. Ogle
Address: R.D. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-31-45 (month) (day) (year)
Cemetery or crematory: Taylorsville
Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C. M. Walsh
Address: Winfield, Md

19. 7/28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945 at 4:A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1945 to July 28 1945 and that I last saw him alive on July 27 1945

Immediate cause of death: Cerebral Thrombosis — DURATION: 5 days
Due to: Arteriosclerosis (Senile) — 2
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. H. Crowden M. D. or other
Address: Westminster Date signed: 7/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

06885 P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C) Bc

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs., 2 mos., 7 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 6 yrs., 2 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 611 South Rose Street (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Peter Panek

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1914

8. AGE: Years 31 | Months 2 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business

FATHER
12. Name Walter Panek
13. Birthplace Poland

MOTHER
14. Maiden name Mary Paskevck
15. Birthplace Poland

16. Informant Records of Springfield State
Address Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13/45 (month) (day) (year)
Cemetery or crematory Holy Rosary
Location Baltimore

18. Funeral director Fred W. Kazmarski
Address 1930 Eastern Ave.

19. 7/11/45 (Date rec'd by registrar) A.W. Frederick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945 to July 10 1945 and that I last saw h... alive on July 10 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	unk.
Due to	
Due to	
Other conditions	
Dementia Praecox, Paranoid (Include pregnancy within 3 months of death)	12 yrs.

Major findings of operations
Date of op.
Autopsy results none.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward F. Kerman M. D. or other
Address Sykesville, Md. Date signed 7-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

CERTIFICATE OF DEATH

06886

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH INKING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: unknown
City or town: South Williamsport 23
(If outside city or town limits, write RURAL and give nearest town)
Street No. 521 Hastings St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: LEE A. PARDOE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 28, 1878

8. AGE:

Years	Months	Days	If less than one day
66	9	5	..... hrs. ..... min.

9. Birthplace: Pennsylvania - Elkland (Town, county, and state)
10. Usual occupation: Printer
11. Industry or business: Govt Printing Office

FATHER
12. Name: Walter T. Pardoe
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Cloie Jackson
15. Birthplace: Pennsylvania

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6, 1945 (month) (day) (year)
Cemetery or crematory: Williamsport Cem.
Location: Williamsport, Pa.

18. Funeral director: C. Harry Klee
Address: Sykesville, Md.

19. July 4 1945 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1945, at 845 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1945, to July 3 1945 and that I last saw h.. alive on July 3 1945

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to	
Due to	
Other conditions: Psychosis; Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	9 mos.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D., or other
Address: S.H. Hosp., Sykesville, Md. Date signed 7-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

C6887 74

Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 24 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Leonard Plaesser

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Eleanora
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 8, 1869

8. AGE: Years	Months	Days	If less than one day
76	5	20	hrs. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: saloon keeper
11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: Germany

MOTHER
14. Maiden name: ?
15. Birthplace: Germany

16. Informant: Springfield State Hospital records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 1, 1945 (month) (day) (year)
Cemetery or crematory: Parkwood Cem.
Location: Balto. Md.
18. Funeral director: John Tyllbuck
Address: 2058 Orleans St. Balto. Md.
19. July 29 1945 (Date rec'd by registrar) C. Harry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945 at 7:18p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945 to July 28 1945 and that I last saw him alive on July 28 1945

Immediate cause of death	DURATION
Arteriosclerosis, prior to	1944
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 7-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on FILM No. G 96 JUL 17 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

66888

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mo

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Washington

City or town Rohrersville
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Hettie Poffenberger

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23 - 1871

8. AGE: Years	Months	Days	If less than one day
74	7-5	4 3	16-17 hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation housework

11. Industry or business at home

FATHER 12. Name John H Poffenberger

13. Birthplace Md

MOTHER 14. Maiden name Sarah Jane Geltmacher

15. Birthplace Md

16. Informant Mrs Lillie Poffenberger

Address Rohrersville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12 45 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md

18. Funeral director Chas T. Bast & Sons

Address Boonsboro Md.

19. July 9 1945 C. Keery Elwell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 1945 at 8 30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 12 1944 to July 9th 1945 and that I last saw her alive on July 9th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 da
Due to	
Due to arterio Sclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W H Mantz M.D. M. D. or Other

Address Sykesville Date signed 7/12

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06889

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs., 6 mos., 14 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 5 yrs., 6 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: Not known (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Martha Pritchard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: HowArd Pritchard
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): December 15, 1911

8. AGE:	Years	Months	Days	If less than one day
	33	7	4	....hrs. ....min.

9. Birthplace: America (Town, county, and state)
10. Usual occupation: None
11. Industry or business: ---

FATHER
12. Name: John Grainger
13. Birthplace: Ireland

MOTHER
14. Maiden name: Emily Ellicott
15. Birthplace: America

16. Informant: Records of Springfield State Hospital, Sykesville, Md.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1945 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Ebert
Address: Sykesville, Md.
19. July 23 1945 C. Harry Ebert (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1945 at 10:10 pm
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6th 1945 to July 19th 1945 and that I last saw h... alive on July 19th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 months
Due to	
Due to	
Other conditions: Schizophrenia, Paranoid type (Include pregnancy within 3 months of death)	7 yrs

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Helmut Prager M.D. M. D. or other
Address: Springfield State Hospital Md. Date signed 7-20-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM NO. G97 JUL 31 1945

06890

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (546)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Near Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Near Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Emory Chapel Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Carroll Guy Raver

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace S. Raver
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1875

8. AGE: Years	Months	Days	If less than one day
~~70~~ 69	10	22	..... hrs. ..... min.

9. Birthplace: Carroll Co. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: J. Franklin Raver
13. Birthplace: Carroll Co.

MOTHER
14. Maiden name: Elizabeth Bond
15. Birthplace: Carroll Co.

16. Informant: Milson Raver
Address: Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 22, 1945 (month) (day) (year)
Cemetery or crematory: Emory Chapel
Location: Carroll Co.

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. 7/23 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1945, at 9 a.m. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 28, 1943, to death 1945
and that I last saw him alive on July 14, 1945

Immediate cause of death	DURATION
Heart failure	
Due to: Arteriosclerosis	one year
Due to:	
Other conditions: Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter Landon, M.D.
M. D. or other
Address: Reisterstown, Md. Date signed: 7-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

06891

CERTIFICATE OF DEATH ★

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Eldersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural - Eldersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Robert Shipley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Sarah E. Shipley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1868

8. AGE:

Years	Months	Days	If less than one day
76	9	18	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm.

FATHER

12. Name: Henry B. Shipley

13. Birthplace: Md.

MOTHER

14. Maiden name: Susan R. Dillinger

15. Birthplace: Md.

16. Informant: Mrs. Dudley E. Shipley

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 1945 (month) (day) (year)

Cemetery or crematory: Wesley Freedom Cem.

Location: Sykesville, Carroll Co., Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. July 14 19 45 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1945 at 6.45 P.M. Before

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary Occlusion	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work? .....

23. SIGNATURE: James T. Hood Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed 7/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

06892

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Franklin Shuman

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Minnie Shuman
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Apr. 18 1863

8. AGE: Years 82 | Months 2 | Days 23 | If less than one day: hrs. min.

9. Birthplace: Clear Mary Land (Town, county, and state)
10. Usual occupation: Retired Engineer
11. Industry or business: Railroad
FATHER 12. Name: unknown
13. Birthplace: Mary Land
MOTHER 14. Maiden name: unknown
15. Birthplace: Mary Land
16. Informant: Minnie Shuman
Address: Manchester, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-14-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Mount Ridge Baltimore Co. Md
18. Funeral director: Jacob R. Zimmerman Sons
Address: Manchester Md.
19. July 12 1945 Mrs. W. R. S. Dennis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1945 at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1945, to July 11 1945
and that I last saw h. alive on July 11 1945

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Chronic Myocarditis ?	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State) —
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Carl E. Buchheit M. D. or other
Address: Hanover Pa. Date signed 7-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

06893

CERTIFICATE OF DEATH ★

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 3 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emily Viola Sickler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Forrest V. Sickler
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): January 18, 1875

8. AGE: Years: 70 | Months: 5 | Days: 12 | If less than one day: ...hrs. ...min.

9. Birthplace: Williamstown, Pennsylvania
(Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business

FATHER
12. Name: ? Biedler
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Emma McPurdy
15. Birthplace: Pennsylvania

16. Informant: Forrest V. Sickler, husband
Address: 5741 Lambeth Rd., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/6/45 (month) (day) (year)
Cemetery or crematory: Williamstown M.E. Cemetery
Location: Williamstown, N. J.

18. Funeral director: C. Harry Klein
Address: Sykesville, Md.

19. July 5 1945 (Date rec'd by registrar) C. Harry Klein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1945, at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to July 3 1945
and that I last saw her alive on July 2 1945

Immediate cause of death	DURATION
Chronic myocarditis	
Due to: generalized arteriosclerosis	
Due to:	
Other conditions: Psychosis & cerebral arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward F. Kernan M.D.
M. D. ~~or other~~
Address: Sykesville Md Date signed 7-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16894

★ Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll 6
City or town: Westminster R.D. No. Smallwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster R.D. 6
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Near Smallwood
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rachel Effie Jane Smeak

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Andrew S. Smeak
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Dec. 27- 1861
8. AGE: Years: 83 Months: 7 Days: 0 If less than one day: hrs. min.
9. Birthplace: Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Retired Housework
11. Industry or business: Retired
FATHER 12. Name: Jacob Brook
13. Birthplace: Carroll Co. Md.
MOTHER 14. Maiden name: Maria Hahn
15. Birthplace: Carroll Co. Md.
18. Informant: Clarence Ricketts
Address: Westminster Md. R.D. 6
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30 1945 (month) (day) (year)
Cemetery or crematory: Bruders Cemetery
Location: Near Westminster, Md.
18. Funeral director: J. M. Linke & Son
Address: Taneytown, Pa. Rt. R.D. 4
19. 7/27 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945 at 2:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1- 1945 to July 27 1945 and that I last saw him alive on July 26 1945

	DURATION
Immediate cause of death: Broncho Pneumonia	4 Days
Due to: Myocarditis	Years
Due to: Arteriosclerosis	6 Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Fenby, M.D. M. D. or other
Address: Westminster Md. Date signed: 7/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06895

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 10 years
Hospital, Institution, or street address where death occurred:
202 E. Green St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 202 E. Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Smelser

3. (b) Social Security Number ? 220-09-5726

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	W.	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1905

8. AGE: Years	Months	Days	If less than one day
about 40			hrs. min.

9. Birthplace Uniontown Fred. Co. Md.
(Town, county, and state)
10. Usual occupation Cook
11. Industry or business restaurant
FATHER 12. Name Albert Smelser
13. Birthplace Fred. Co. Md.
MOTHER 14. Maiden name Effie Greenholtz
15. Birthplace Fred. Co. Md.
16. Informant H. E. Greenholtz
Address 4606 Reisterstown Rd. Balto. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1 45 (month) (day) (year)
Cemetery or crematory Evergreen Cem.
Location Uniontown Fred Co. Md.
18. Funeral director J. E. Myers Jr.
Address Westminster Md.
19. 7/30 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 45, at Prior to 5:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Marsh Deputy Medical Examiner M. D. or other
Address Westminster Md. Date signed 7/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06896

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 29 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore tt Place
(If outside city or town limits, write RURAL and give nearest town)
Street No. 926 Bennett Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JAMES STEVENS, JR.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 20, 1927

8. AGE: Years	Months	Days	If less than one day
18	2	7	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business

FATHER
12. Name: James Stevens
13. Birthplace: Cambridge, Md.

MOTHER
14. Maiden name: Gertrude Millicent
15. Birthplace: Charles County, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-31-45 (month) (day) (year)
Cemetery or crematory: Arbutus Park
Location:

18. Funeral director: Mrs. Hemsley
Address: 578 W. Biddle St, Balto.

19. July 27, 1945 (Date rec'd by registrar) Albert K. Grumbacher Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1945 at 1:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28, 1945 to July 27, 1945 and that I last saw him alive on July 27, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	March 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed 7-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

06897

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 mos.

Hospital, Institution, or street address where death occurred:

155 Liberty St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 155 Liberty St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harriette Margaritanne Stultz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Charles D Stultz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 3 1864

8. AGE:

Years	Months	Days	If less than one day
80	8	6	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Thadeus R Flundberg

13. Birthplace Germany

MOTHER 14. Maiden name Barbara Gingling

15. Birthplace Carroll Co. Md.

16. Informant Mrs. B. H. Young

Address 155 Liberty St. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11-1945 (month) (day) (year)

Cemetery or crematory St. Johns Cem.

Location Westminster Md.

18. Funeral director J. Bankard & Son

Address Westminster, Md.

19. 7/10 1945 H. Meade Reg.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 1945, at 6a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1st 1944 to July 9. 1945 and that I last saw her alive on July 8th 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	after thirty days
Due to Chronic Myocarditis	10 years
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. R Fouty MD M. D. or other

Address Westminster Md. Date signed 7/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

06898

CERTIFICATE OF DEATH ★ Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

Street No. WASHINGTON RD.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: W. FRANK THOMAS

3.(b) Social Security Number: 217-05-9602

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: ANNE LLOYD

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 30, 1899

8. AGE: Years: 65 | Months: 7 | Days: 15 | If less than one day: ...hrs. ...min.

9. Birthplace: WESTMINSTER, MD.
(Town, county, and state)

10. Usual occupation: ROAD CONSTRUCTION (RETD)

11. Industry or business

FATHER
12. Name: WILLIAM B. THOMAS
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: REBECCA FENTON
15. Birthplace: MARYLAND

16. Informant: MRS. W.F. THOMAS
Address: WESTMINSTER, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/17/45 (month) (day) (year)

Cemetery or crematory: WESTMINSTER CEM.

Location: WESTMINSTER, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 7/16/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945, at 9:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1945 to July 15 1945 and that I last saw him alive on July 15 1945

Immediate cause of death	DURATION
Coronary Occlusion	1 hr.
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Thomas M. D. or other

Address: Westminster Md Date signed 7/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06899

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1408 Argyle Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: AMOS THOMPSON

3.(b) Social Security Number: 227-16-7291

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 22, 1917

8. AGE: Years	Months	Days	If less than one day
27	10	23	hrs. min.

9. Birthplace: Union, South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Samuel Thompson
13. Birthplace: Union, S.C.

MOTHER
14. Maiden name: Viola Dawkins
15. Birthplace: Union, S.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-17-45 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: A W
18. Funeral director: Elroy O. Wilson
Address: 1000 Bentley ave

19. July 15, 1945 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15, 1945 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 28, 1945 to July 15, 1945 and that I last saw him alive on July 15, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Dec. 23, 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 7-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06900

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 month, 21 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1025 N. Caroline St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
ANNIE THOMPSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1930

8. AGE: Years	Months	Days	If less than one day
15	4	8	hrs. min.

9. Birthplace Chester, S.C.
(Town, county, and state)
10. Usual occupation Scholar
11. Industry or business at school

FATHER
12. Name Theodore Thompson
13. Birthplace Chester, S. C.

MOTHER
14. Maiden name Mattie Gladen
15. Birthplace Chester, S. C.

16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.

17. Burial Date thereof July 24. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
Location annapolis Road.
18. Funeral director MRS Robert Elliott & daughter
Address 1129 N. Caroline St.

19. 7/21 19 45 Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 19 45 at 6.25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 19 45 to July 21, 19 45 and that I last saw her alive on July 21, 19 45

	DURATION
Immediate cause of death Pulmonary Tuberculosis	Feb. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M. D.
M. D. or other
Address Henryton, Md. Date signed 7/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84d)

CERTIFICATE OF DEATH

06901

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 9 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Baltimore County ----
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1370 Andrea Street
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Frances Vacovsky

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Albert Vacovsky
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54	?	?	..... hrs. ..... min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual occupation Domestic work
11. Industry or business ----

FATHER
12. Name John Mathews
13. Birthplace Czechoslovakia

MOTHER
14. Maiden name Mary ?
15. Birthplace Czechoslovakia

16. Informant Records of Springfield State Hospital, Sykesville, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/7/45 (month) (day) (year)
Cemetery or crematory xx Oak Hill
Location Phila. Rd. Balto. Md.

18. Funeral director Charles E. Schimunek
Address 2601 E. Madison Street

19. 7-6 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945 at 9:39a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1945 to July 4 1945 and that I last saw her alive on July 4, 1945

Immediate cause of death	DURATION
Mesenteric Thrombosis	3 days
Due to	
Due to	
Other conditions: Alzheimer's Disease (Include pregnancy within 3 months of death)	

Major findings of operations Necrosis of transverse Colon Date of op. 7-3-45
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Edward J. Kernan M. D. or other
Address Sykesville, Md. Date signed 7-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (THA)

CERTIFICATE OF DEATH ★

06902

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll Co.
City or town Fountain Valley near West Minster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural, near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Fountain Valley
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie Forney Warehime

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife Howard W. Warehime
6.(c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) April 9, 1866

8. AGE:

Years	Months	Days	If less than one day
79	3	2	..... hrs. ..... min.

9. Birthplace Fountain Valley Carroll Co. Md.
(Town, county, and state)
10. Usual occupation house - wife
11. Industry or business
FATHER 12. Name Emmanuel Forney
13. Birthplace Penna.
MOTHER 14. Maiden name Mary Petry
15. Birthplace Penna.
16. Informant Mr. Howard W. Warehime
Address Westminster R.D. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/13/45 (month) (day) (year)
Cemetery or crematory Mother Branch Cem.
Location Near Westminster Md
18. Funeral director J. E. Myers Jr.
Address Westminster Md
19. 7/12 19 45 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 19 45 at 10:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
..... Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE James T. Marsh, Deputy, Medical Examiner
M. D. or other
Address Westminster Md Date signed 7/11/45

06903

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94@)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown
(If ontside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clara S. Welk

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife Charles P. Welk

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 16, 1872

8. AGE:	Years	Months	Days	If less than one day
	72	9	14	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER — 12. Name Wesley Segafoose

13. Birthplace Maryland

MOTHER — 14. Maiden name Mary Winters

15. Birthplace Maryland.

18. Informant Mr. Walter Welk

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 2, 1945 (month) (day) (year)

Cemetery or crematory Baust Church Cemetery

Location Tyrone, Md. (Near Taneytown)

18. Funeral director C.O. Fuss & Son

Address Taneytown, Md.

19. Aug. 1 (Date rec'd by registrar) 19 45 Mary B. Welk Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1945 at 9.45P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1937 to July 30 1945 and that I last saw her alive on July 30 1945

Immediate cause of death	DURATION
Coronary Occlusion	12 hrs.
Due to Cholecystitis (chronic)	4yrs.
Due to	
Due to	
Other conditions Umbilical hernia	30yrs.?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis J. Elliot M.D. M. D. or other

Address Taneytown, Maryland Date signed July 31, 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH ★

06904

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll ,

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 1 mo., 13 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1138 Argyle Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ELIZABETH WILSON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Stanley Wilson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1907

8. AGE: Years	Months	Days	If less than one day
37	8	2	hrs. min.

9. Birthplace: Goodwill, West Virginia (Town, county, and state)

10. Usual occupation: Elevator Operator

11. Industry or business

FATHER — 12. Name: George Dawson

FATHER — 13. Birthplace: Goodwill, West Virginia

MOTHER — 14. Maiden name: Anna Webb

MOTHER — 15. Birthplace: Goodwill, West Virginia

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 7/10/45 (month) (day) (year)

Cemetery or crematory:

Location: Roanoke, Virginia

18. Funeral director: Mrs. Frances F. Kemsley

Address: 578 W. Biddle St.

19. July 9, 1945 (Date rec'd by registrar) Albert R. Sanderlin Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9, 1945 at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26, 1944 to July 9, 1945 and that I last saw her alive on July 9, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 7-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

06905

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Marston
(If outside city or town limits, write RURAL and give nearest town)
How long in abeve place of death? 24 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Marston
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD. New Windsor
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Pearlie Ann Wilt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband ~~or wife~~: John D. Wilt deceased
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 1, 1882

8. AGE:

Years	Months	Days	If less than one day
63	3	16	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: Nathan Frank Lee
13. Birthplace: Maryland
MOTHER 14. Maiden name: Martha Grimes
15. Birthplace: Maryland.
16. Informant: Mr. Harry F. Wilt
Address: New Windsor, Md
17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 7-20-45 (month) (day) (year)
Cemetery or ~~crematory~~: Taylorsville
Location: Taylorsville Carroll Co. Md
18. Funeral director: C. M. Wolfe
Address: Westfield Md
19. July 19 1945 (Date rec'd by registrar) Ernest L. Bunder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1945, at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1945, to July 17 1945
and that I last saw h.~~e/r~~ alive on July 17 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Arterio Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. N. Legg M. D. or other
Address: Union Bridge Date signed 7-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

06906

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 5 mos., 13 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 2 yrs., 5 mos., 13 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 443 N. Lakewood Ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH John WIRTH, JR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Marie E. Wirth (nee Lentz) 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 20, 1888

8. AGE: Years	Months	Days	If less than one day
56	7	22	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Woodworker
11. Industry or business: Woodworking Company
FATHER 12. Name: Joseph J. Wirth
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Ella Mary Lantz
15. Birthplace: Baltimore, Md.
16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: 3310 Taylor Ave. Balto. Md.
18. Funeral director: Charles E. Schimunek
Address: 2601-03 E. Madison Street

19. 7/13/45 (Date rec'd by registrar) Alw Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1945 at 2:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29 1943 to July 12 1945 and that I last saw h... alive on July 12 1945

Immediate cause of death	DURATION
Cerebral thrombosis	1 day
Due to	
Due to	
Other conditions: Chronic alcoholism without psychosis; Pseudo-bulbar palsy (include pregnancy within 3 months of death)	?

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other
Address: S. S. Hosp., Sykesville, Md. Date signed: 7-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1628 McCulloh St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LLOYD WALTER WOOD

3.(b) Social Security Number: 218-01-2411

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Eva Wood
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): May 25, 1904

8. AGE: Years	Months	Days	If less than one day
41	2	2	....hrs. ....min.

9. Birthplace: Lancaster, Va.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: John Wood
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ella Kelley
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/27/45 (month) (day) (year)
Cemetery or crematory: Mt Vernon Baptist Cem.
Location: Whitestone, Va.
18. Funeral director: Chas H Worfel
Address: 512 Cawellton Ave.

19. July 27, 1945 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20, 1944, to July 27, 1945 and that I last saw him alive on July 27, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Sept. 4 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed: 7-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15